

Individual, Marriage, & Family Enrichment

601 West Nifong Blvd. – Building 1 Suite 1E
Columbia, MO 65203

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize _____

to disclose to _____ the following information:

I understand that my records are kept confidential and protected under State and Federal laws concerning patient privacy and confidentiality and regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Consent expires on: _____

Signature of Client: _____ Date: _____

Printed name of Client: _____

Signature of Witness: _____